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FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12764

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12759

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (DOA) Garrett Co. Memorial Hospital		e. STREET ADDRESS Accident	
3. NAME OF DECEASED (Type or print) Robert Lee Bittner		First	Middle
4. DATE OF DEATH Sept. 19th. 1966	Month	Day	Year
S. SEX M	6. COLOR OR RACE W	7. MARRIED NEVER MARRIED WIDOWED DIVORCED	8. DATE OF BIRTH 7/10/1914
9. AGE (In years lost birthday) 52 yrs.	10. KIND OF BUSINESS OR INDUSTRY U.S. Air Force Retired	11. BIRTHPLACE (State or foreign country) Garrett Co., Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Harvey Bittner	14. MOTHER'S MAIDEN NAME Annie Durst	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. 216-03-8553		17. INFORMANT Mrs. Rhoda Bittner, Accident, Md.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED OAKLAND, MD. 9-19-66	
ACTUAL SIGNATURE James H. Feaster, Jr., M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/22/66	23c. NAME OF CEMETERY OR CREMATORIAL Grantsville Cem.
24. FUNERAL DIRECTOR Ruth E. Newman		23d. LOCATION (City or Town) (County) (State) Grantsville, Garrett, Md.	
25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE SEP 26 1966	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12762

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 6Hr. 13 Min.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		d. STREET ADDRESS Box 82	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby		4. DATE OF DEATH Month September Day 22 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9-22-66
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (County & State, or foreign country) Garrett, Maryland	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Carolyn Elaine Broadwater	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Carolyn Broadwater see # 2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency 7593 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Multiple Congenital defects		INTERVAL BETWEEN ONSET AND DEATH 6 1/2 months	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-22-1966 to 9-22-1966 , that (I) (we) last saw the deceased alive on 9-22-1966 , and that death occurred at 2:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. H. Leighton		22b. DATE SIGNED 23 Sept 66	
22c. PHYSICIAN'S NAME (Type) Dr. H. Leighton		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/23/66	23c. NAME OF CEMETERY OR CREMATORIAL Garrett Co. Mem. Gardens
24. FUNERAL DIRECTOR Gerald D. Minnich		ADDRESS Oakland, Maryland	25a. RECD BY REGISTRAR OCT 3 1966
			25b. REGISTRAR'S SIGNATURE Charles J. Gege

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN lb 7 days-8 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		d. STREET ADDRESS Route #2,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Edna	Last Calhoun
4. DATE OF DEATH September 24, 1966	Month September	Day 24	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Hoyes, Garrett, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Kimmell		14. MOTHER'S MAIDEN NAME Maggie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT (Daughter) Mrs. Mulvey, James		Address Rt 2, Oakland, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADVANCED CONGESTIVE FAILURE WITH GENERALIZED ANAEROB			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) due to DUE TO (c) Anisakiasis Onder verden Dese			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) Oakland		(County) Maryland	
(State) MD			
21. I certify that (I) (this hospital) attended the deceased from SEP 16 1966 to SEP 24 1966 , that (I) (we) last saw the deceased alive on SEP 23 1966 , and that death occurred at 5:00A.M. from causes and on the date stated above.			
22c. PHYSICIAN'S NAME (Type) Dr. E. I. Baumgartner		22b. DATE SIGNED 9/24/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/26/66	23c. NAME OF CEMETERY OR CREMATORIAL Pleasant Valley Cem.
24. FUNERAL DIRECTOR Durst John O. Durst ADDRESS Leighton-Durst Funeral Home, Oakland, Md.		25a. REC'D BY REGISTRAR DATE SEP 27 1966	25b. REGISTRAR'S SIGNATURE John O. Durst

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Item 20b Film 380 9-19-66 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12767 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12761

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland Minutes		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (DOA) Garrett Co. Mem. Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) TAMMY		First LOUISE	Middle COLLINS
4. DATE OF DEATH Sept. 13th. 1966	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
8. DATE OF BIRTH June 10, 1965	9. AGE (In years last birthday) 1 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Oakland, Garr., Md.	
11. BIRTHPLACE (State or foreign country) Oakland, Garr., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence Wm. Collins		14. MOTHER'S MAIDEN NAME Barbara Warnick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clarence W. Collins, Deer Park, Md.		Address (Father)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 902.0		INTERVAL BETWEEN ONSET AND DEATH Minutes	
(b) Contusion of brain DUE TO		Minutes	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Fell from crib and struck head.	
20c. TIME OF INJURY Month, Day, Year Hour <input checked="" type="checkbox"/> 6:30 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home
20f. (City or town) Dear Park Garrett, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Feaster, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 9-13-66			
Address (Street, city, town, or county) Oakland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/16/66	23c. NAME OF CEMETERY OR CREMATORIAL Dear Park Cemetery
24. FUNERAL DIRECTOR John O. Durst		ADDRESS John O. Durst Leighton-Durst Funeral Home, Oakland, Md.	
25a. REC'D BY REGISTRAR SEP 16 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

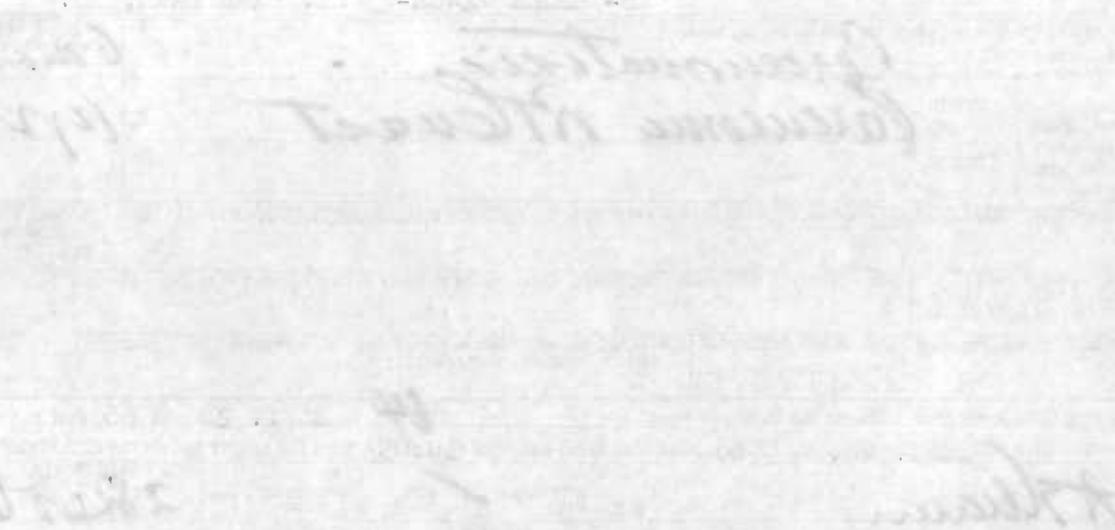
1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
12768 CERTIFICATE OF DEATH 12763													
1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OAKLAND			c. LENGTH OF STAY IN 1b 2 DAYS			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MT. LAKE PARK							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL						d. STREET ADDRESS							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First FREDA	Middle FER	Last DUNGEY	4. DATE OF DEATH SEPTEMBER 28, 1966	Month Day Year	5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 26, 1907	9. AGE (In years last birthday) 59 yrs.	10. IF UNDERTAKER 11. BIRTHPLACE (County & State, or foreign country) W. VA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) W. VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM EDWARD VANCE				14. MOTHER'S MAIDEN NAME ELLA RODERMAN									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
NO				B- KELLY VANCE -		MT. LAKE PARK, MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous</i> 170X <i>Carcinoma RT Breast</i> INTERVAL BETWEEN ONSET AND DEATH 6 mos.													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				OUT TO (b) <i>Carcinoma RT Breast</i> DUE TO (c)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERTAKING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19													
21. I certify that (I) (this hospital) attended the deceased from <i>1964</i> , to <i>SEPT. 28, 1966</i> , that (I) (we) last saw the deceased alive on <i>SEPT. 28, 1966</i> , and that death occurred at <i>10:05M</i> , from the causes and on the date stated above.													
22a. SIGNATURE <i>A. E. Magee</i>													
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>28/9/66</i>					
Dr. A. E. MAGEE													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/1/66		23c. NAME OF CEMETERY OR CREMATORIUM Bayard Cemetery		23d. LOCATION (City, town or county) Bayard, W. Va.		(State)					
		ADDRESS											
24. FUNERAL DIRECTOR <i>Gerald D. Minnich</i>		25a. REC'D BY REGISTRAR OCT 3 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

CURSI



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HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12764

12763		MEDICAL EXAMINER'S CERTIFICATE OF DEATH								12764	
<p>1. PLACE OF DEATH a. COUNTY Garrett MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland</p> <p>c. LENGTH OF STAY IN lb 2 days</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett Co. Memorial Hospital</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE Md.</p> <p>b. COUNTY Garrett</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland - R.D. 1</p> <p>d. STREET ADDRESS</p>				<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) Tda</p> <p>4. DATE OF DEATH September 15th</p>		<p>First Hager</p> <p>Middle</p> <p>Last</p>		<p>Month 19</p>		<p>Day 66</p>					
<p>5. SEX Female</p> <p>6. COLOR OR RACE White</p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>B. DATE OF BIRTH 2-16-77</p>		<p>9. AGE (in years last birthday) 89</p>		<p>10. IF UNDER 1 YEAR <input type="checkbox"/> Months 0</p> <p>IF UNDER 24 HRS. <input type="checkbox"/> Days 0</p> <p>Hours 0</p> <p>Min. 0</p>					
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY Own Home</p>		<p>11. BIRTHPLACE (State or foreign country) Garrett Co., Md.</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>					
<p>13. FATHER'S NAME James P. Wiley</p>		<p>14. MOTHER'S MAIDEN NAME Barbara Meyers</p>		<p>15. INFORMANT Mrs. Ruth Leiby, Oakland, Md.</p>		<p>Address</p>					
<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT</p>		<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Hypostatic pneumonia</p> <p>5022X</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____</p> <p>DUE TO _____</p> <p>(c) _____</p>		<p>INTERVAL BETWEEN ONSET AND DEATH 7 days</p>					
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)</p> <p>Fracture of left hip. Open reduction Cumberland, Md. 8-14-66</p>		<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. 8-14-66 19</p>		<p>20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home</p>		<p>20e. (City or town) Rural Oakland Garrett, Md.</p>			
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>		<p>22. DATE SIGNED 9-15-66</p>									
<p>ACTUAL SIGNATURE James H. Feaster, Jr., M.D.</p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>									
<p>EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.</p>		<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>									
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>23b. DATE THEREOF 9/18/66</p>		<p>23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Grantsville Cemetery</p>		<p>23d. LOCATION (City or Town) Grantsville, Garrett, Md.</p>					
<p>24. FUNERAL DIRECTOR Ruth E. Newman</p>		<p>25a. REC'D BY REGISTRAR</p>		<p>25b. REGISTRAR'S SIGNATURE Charles Judge</p>							
<p>VR A15ME (5) 6M 1/66</p>		<p>DATE SEP 26 1966</p>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12770		12765	
<p>1. PLACE OF DEATH a. COUNTY GARRETT</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND</p> <p>c. LENGTH OF STAY IN 1b 5 YEARS</p> <p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CUPPET NURSING HOME</p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND</p> <p>b. COUNTY ALLEGANY</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG</p> <p>d. STREET ADDRESS BROADWAY</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) Leota M. Miller</p> <p>First Leota Middle M. Last Miller</p> <p>4. DATE OF DEATH Sept. 14 1966</p>		<p>5. SEX F</p> <p>6. COLOR OR RACE W</p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Apr 18 1873</p> <p>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 93 yrs.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY OWN HOME</p>	
<p>11. BIRTHPLACE (State or foreign country) MARYLAND</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME OLIVER WILLIAMS</p>		<p>14. MOTHER'S MAIDEN NAME UNKNOWN</p>	
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None</p>		<p>16. SOCIAL SECURITY NO. OLIVER B. WITTIG, FROSTBURG, MD.</p>	
<p>17. INFORMANT OLIVER B. WITTIG, FROSTBURG, MD.</p>		<p>Address</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mycocardial infarction</i></p> <p>4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Anterior descending CC Disease</i></p> <p>DUE TO (c)</p>		<p>INTERVAL BETWEEN ONSET AND DEATH months</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a. m. 19</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) FROSTBURG, MD.</p>	
<p>(County)</p>		<p>(State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from Sept 6 1966 to Sept 6 1966, that (I) (we) last saw the deceased alive on Sept 6 1966, and that death occurred 7:20 AM, from the causes and on the date stated above.</p>		<p>22b. DATE SIGNED</p>	
<p>22a. SIGNATURE <i>B.L. Gravitt M.D.</i></p>		<p>M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>	
<p>22c. PHYSICIAN'S NAME (Type) <i>B.L. Gravitt M.D.</i></p>		<p>22d. ADDRESS</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL</p>		<p>23b. DATE THEREOF 9-16-66</p>	
<p>23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEMORIAL PARK</p>		<p>23d. LOCATION (City, town, or county) FROSTBURG, MD.</p>	
<p>24. FUNERAL DIRECTOR'S SIGNATURE JOSEPH R. DURST, SR., FROSTBURG, MD.</p>		<p>25a. REC'D BY REGISTRAR DATE SEP 10 1966</p>	
<p>ADDRESS</p>		<p>25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i></p>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12766

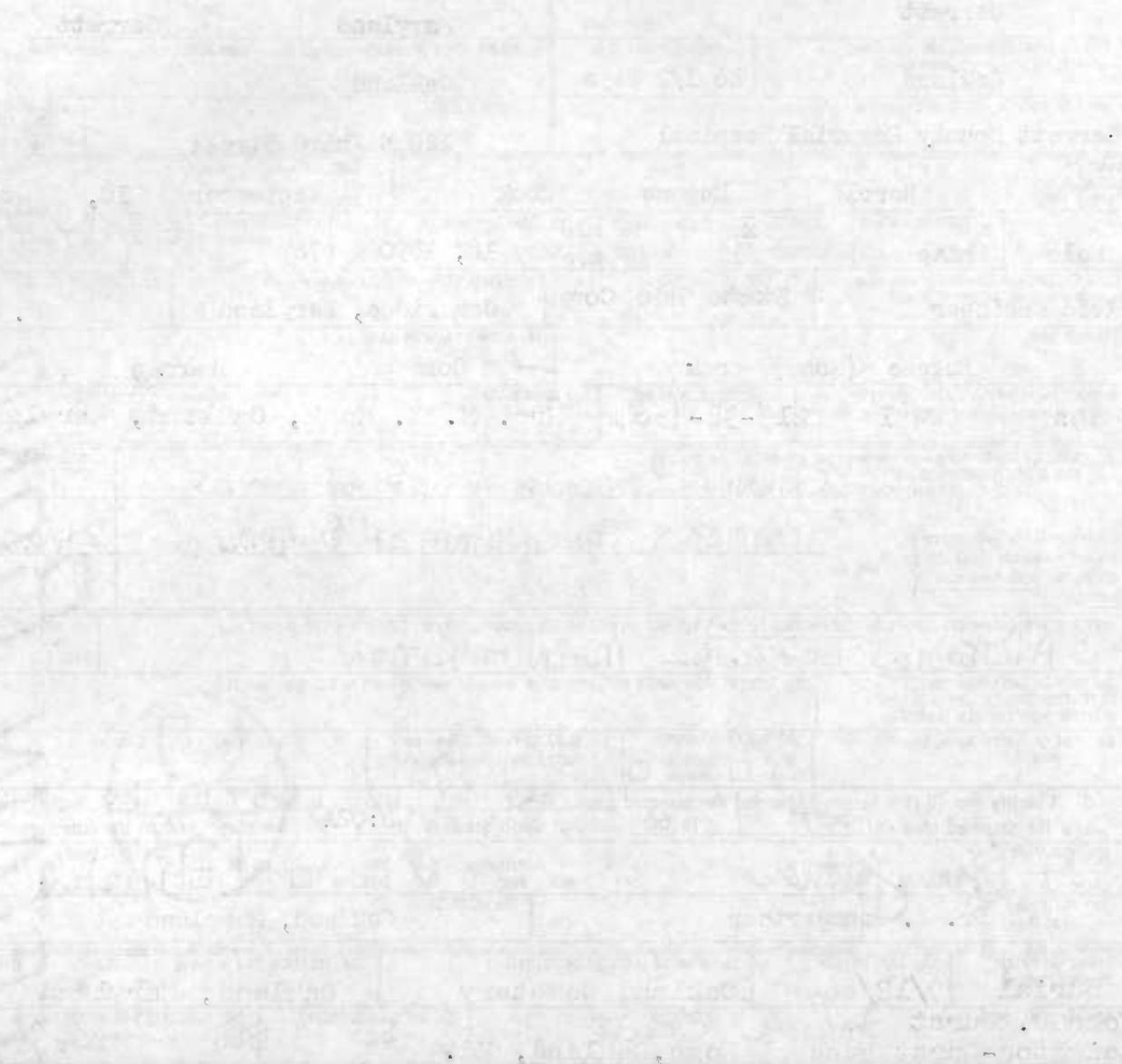
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 46 1/2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		d. STREET ADDRESS 120 N Third Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harold		First Eugene	Middle Rook
4. DATE OF DEATH September 10, 1966	Month 10,	Doy 1966	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DOB. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Road Engineer		9. DATE OF BIRTH May 18, 1890	
10. KIND OF BUSINESS, OR Sister Rds Comm		11. AGE (In years last birthday) 76 yrs.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Eugene (None) Rook		14. MOTHER'S MAIDEN NAME Cora Sherman (Widow)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) Yes		16. SOCIAL SECURITY NO. 215-34-4564	
17. INFORMANT Mrs. H. E. Rook, Oakland, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EXTENSIVE CARCINOMATOSIS OF LUNGS</u>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) <u>PRIMARY CARCINOMA OF BLADDER</u>		24 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1810</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ALTEZIOSISCLEROSIS</u> <u>MAZNU RITION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>66</u> to <u>SEPT 10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>SEPT. 9</u> 19 <u>66</u> , and that death occurred at <u>4:02A</u> M, from causes and on the date stated above.		22a. DATE SIGNED <u>9/12/66</u>	
22b. SIGNATURE <u>E. Baumgartner</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Dr. E. Baumgartner		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/12/66	23c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery
24. FUNERAL DIRECTOR John O. Durst		ADDRESS Leighton-Durst Funeral Home, Oakland, MD	25a. RECEIVED BY REGISTRAR SEP 13 1966
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

10001

10001



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12772

12768

1. PLACE OF DEATH

a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Oakland

c. LENGTH OF STAY IN lb

7 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Cuppett-Weeks Nursing Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

Annie

Catherine

Schuncke

5. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

7. MARRIED

NEVER MARRIED

B. DATE OF BIRTH

WIDOWED

DIVORCED

Mar. 5, 1872

9. AGE (In years last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

94

Months

Days

Hours

Min.

13. FATHER'S NAME

John Rice

14. MOTHER'S MAIDEN NAME

Catherine O'Malley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

none

Mrs. W. Robert Nethken Potomac, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.
(b)
(c)

Septicemia

Pyelitis - Pneumonitis

INTERVAL BETWEEN
ONSET AND DEATH

24 hours

24 hours

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Arteriosclerotic Cardio Vascular Disease

19. WAS AUTOPSY
PERFORMED?YES NO 20e. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY
Hour a.m. Month, Day, Year
p.m. 1920d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Apr. 20, 1960, to Sept. 4, 1966, that (I) (we) last saw the deceased alive on Sept. 3, 1966, and that death occurred at M, from the causes and on the date stated above.

22e. SIGNATURE

H. H. Leighton

M.D.

22b. DATE
SIGNED

5 Sept 66

22e. PHYSICIAN'S
NAME (Type)

Herbert H. Leighton, M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

Oak @ Fifth Streets, Oakland, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

9/6/66

23c. NAME OF CEMETERY OR CREMATORI

New Cathedral Cemetery

23d. LOCATION (City, town or county)

Baltimore Maryland

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

J. A. Minnick

ADDRESS

Oakland, Maryland

25a. REC'D BY REGISTRAR

DATE

SEP 15 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12768

12773		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland Kitzmiller	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland 58 days		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cuppett-Weeks Nursing Home		d. STREET ADDRESS East Main St.	
3. NAME OF DECEASED (Type or print) First Hannah Middle Lucinda Last Sharpless		4. DATE OF DEATH Sept. 8th. Month Day Year 19 66	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED Widowed <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 21, 1877 9. AGE (In years to birthday) 88 yrs. 10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11b. KIND OF BUSINESS OR INDUSTRY Own Home	
11c. BIRTHPLACE (State or foreign country) Garrett Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Wilson		14. MOTHER'S MAIDEN NAME Emily Harvey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-48-4614 17. INFORMANT J. Paul Ewing, Kitzmiller, Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		20. WAS EXTERNAL CAUSE PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH?	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED	
ACTUAL SIGNATURE James H. Feaster, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oakland, Md. 9-8-66	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF Sept. 11/66 23c. NAME OF CEMETERY OR CREMATORIAL O.O.O.F. Cemetery	
23d. LOCATION (City or Town) (County) (State) Elk Garden, Mineral Co., Va.			
24. FUNERAL DIRECTOR ADDRESS Blaine, W. Va. P.O. Box 111, Kitzmiller, Md.			
25a. REC'D BY REGISTRAR DATE SEP 13 1966 25b. REGISTRAR'S SIGNATURE Charles Judge			

40781

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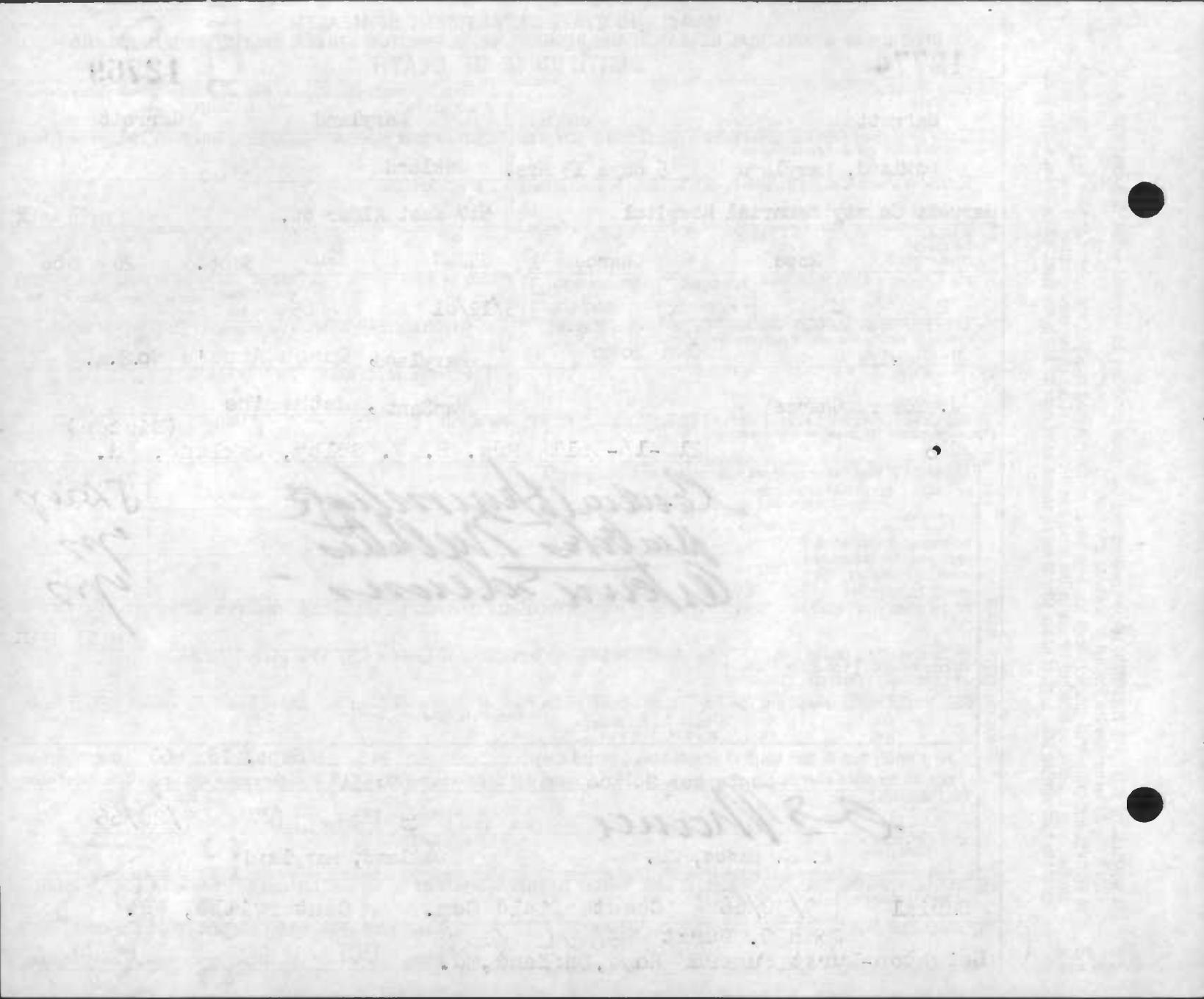
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M
12774 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH
12769

1. PLACE OF DEATH a. COUNTY Garrett		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, Maryland		c. LENGTH OF STAY IN 1b 5 days 13 Hrs		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		d. STREET ADDRESS 517 East Alder St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Rose	Middle Chance	Last SHAWN	4. DATE OF DEATH Sept. 28 1966	Month Sept.	Day 28	Year 1966		
5. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/12/81	9. AGE (In years last birthday) 85 yrs.	10. UNDER 1 YEAR Months 85	11. UNDER 24 HRS. Days 0	12. FUNDER 1 YEAR Hours 0	13. FUNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Queen Anne's Co.S.A.			
13. FATHER'S NAME J. Edward Chance		14. MOTHER'S MAIDEN NAME VanSant, Katherine		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-16-9611		17. INFORMANT Mrs. B. F. Selby, Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO diabetes mellitus artery sclerosis		INTERVAL BETWEEN ONSET AND DEATH sharp 9/27 9/27		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Md.		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 28, 1966</u> , to <u>Sept. 28, 1966</u> , that (I) (we) last saw the deceased alive on <u>September 28 1966</u> , and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above.		22a. SIGNATURE A. E. Chance		22b. DATE SIGNED 9/28/66					
22c. PHYSICIAN'S NAME (Type) A. E. Mance, MD.		22d. ADDRESS Oakland, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/30/66	23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield Cem.	23d. LOCATION (City, town or county) Centerville, Md.	(State)				
24. FUNERAL DIRECTOR Leighton-Durst Funeral Home, Oakland, Md.		ADDRESS John O. Durst	25a. REC'D BY REGISTRAR John O. Durst	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE OCT 3 1966				
VR A15 (4) 15M 4-64									



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12775 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12776

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Anna A. Stanton		First	Middle	Lost	4. DATE OF DEATH Sept. 16, 1966	Month	Doy	Year
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S. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1876	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Grantsville, Md.	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Jonas E. Gnagey	14. MOTHER'S MAIDEN NAME Elizabeth Swauger
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Harriet Powell, Alexandria, Va.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH Minutes
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Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201	(b) <u>Coronary sclerosis</u>	Years
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DUE TO	(c) <u>Arteriosclerosis, generalized</u>	Years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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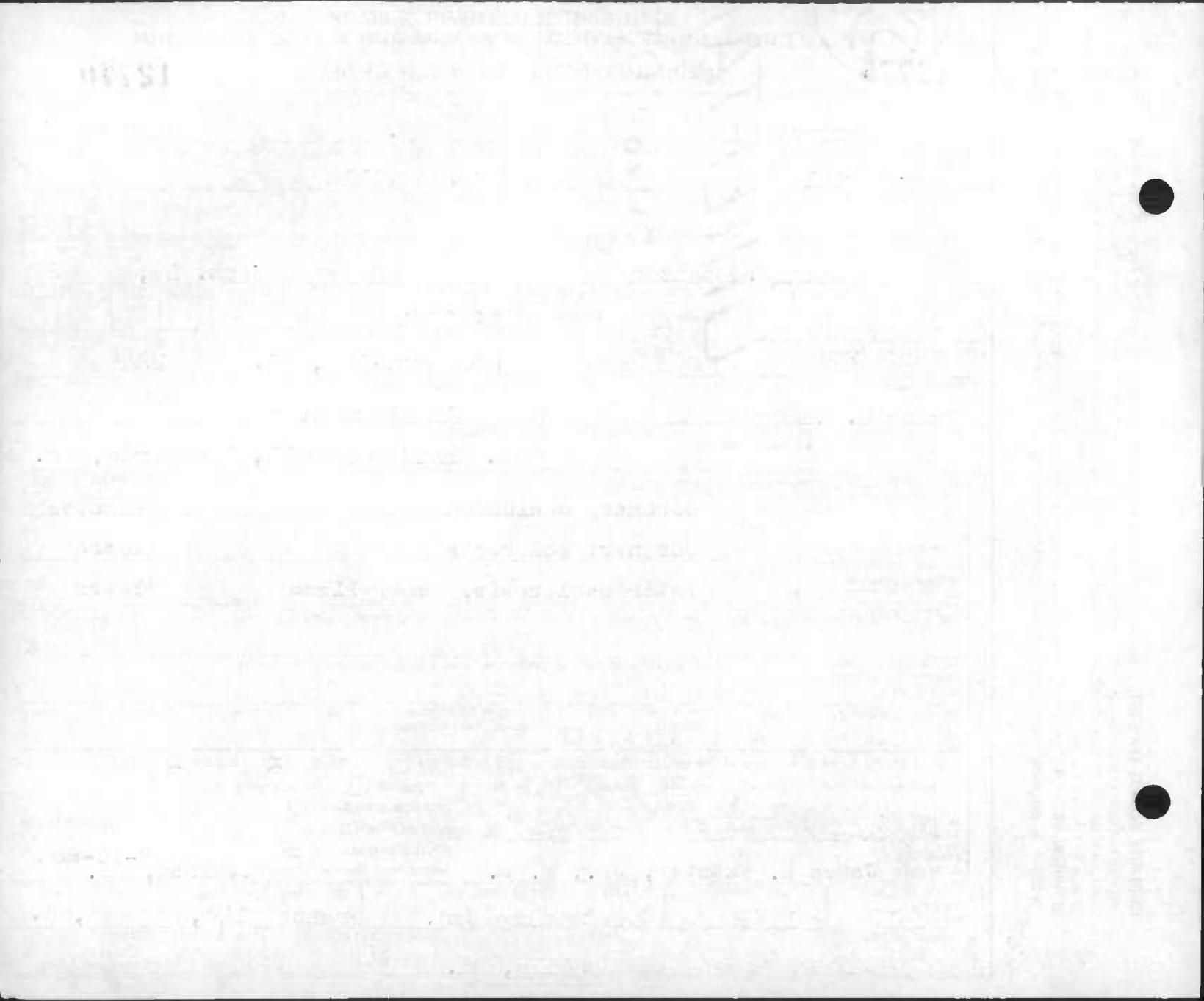
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
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ACTUAL SIGNATURE <u>James H. Feaster, Jr., M. D.</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED 9-16-66
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EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
--	---

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/19/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Grantsville Cem.	23d. LOCATION (City or Town) (County) (State) Grantsville, Garrett, Md.
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24. FUNERAL DIRECTOR Ruth E. Newman	ADDRESS Grantsville, Md.	25a. REC'D BY REGISTRAR DATE SEP 25 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, ages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12276

Item #9 Film #381 9/27/66 pg

12771

1. PLACE OF DEATH
a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Oakland,

c. LENGTH OF STAY IN 1b

18 Rs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Garrett Co. Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

William

Fred

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

December 9, 1903

9. AGE (In years
last birthday)

16305
Months

Yrs.

10. IF UNDER 1 YEAR
Months

Days

11. IF UNDER 24 HRS.
Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Railway Mail Clerk

10b. KIND OF BUSINESS OR INDUSTRY

U. S. Government

11. BIRTHPLACE (County & State, or lone country)

Terra Alta, West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Oscar Whetsell

14. MOTHER'S MAIDEN NAME

Lou Browning

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or dates of service)

No.

16. SOCIAL SECURITY NO.

235-70-0343

17. INFORMANT

Mrs. Luenette Whetsell Terra Alta, W.Va.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Heart Failure

Myocardial infarction

Coronary occlusion w/ atherosclerosis

INTERVAL BETWEEN
ONSET AND DEATH

2 days

Sudden

2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. TIME OF INJURY
Hour a.m. 20b. INJURY OCCURRED
at work at work

20c. TIME OF INJURY
Hour a.m. 20d. INJURY OCCURRED
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Month, Day, Year
19

21. I certify that (I) (this hospital) attended the deceased from Nov 18, 1960 to Sept 16, 1966, that (I) (we) last
saw the deceased alive on 19 66, and that death occurred at 4:15A, from the causes and on the date stated above.

22a. SIGNATURE

Charles Smith

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

22c. PHYSICIAN'S
NAME (Type)

Dr. Charles Smith

22d. ADDRESS

Terra Alta, West Virginia

23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

23b. DATE THEREOF
9/19/66

23c. NAME OF CEMETERY OR CREMATORI

Terra Alta Cemetery

23d. LOCATION (City, town or county)

(State)

Terra Alta, West Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

John R. Whetsell

ADDRESS

Terra Alta, W.Va.

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE SEP 23 1966 Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12772

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND, Md.		c. LENGTH OF STAY IN lb 2 DAYS 14 HRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) THE GARRETT CO. MEMORIAL HOSPITAL		d. STREET ADDRESS STAR ROUTE	
3. NAME OF DECEASED (Type or print) CHARLES		First (None)	Middle WIL TREK
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY W. Penn Power Co.	
11. BIRTHPLACE (County & State, or foreign country) PEKKA Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WIL TREK, JOSEPH		14. MOTHER'S MAIDEN NAME Agnes Lasitis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WV 1 69-07-7220	
17. INFORMANT FRANCES WIL TREK (WIFE)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN DEATH AND DEATH 25 days	
Cerebral Hemorrhage Diabetes Mellitus Atherosclerosis -		7 yrs 7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7485 1/2
20f. (City or town) Westmoreland Co., Pa.		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7485 1/2 , to 9-28-66 , that (I) (we) last saw the deceased alive on 9-28-66 19, and that death occurred at 7:07 AM , from causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE A.E. Mance		22b. DATE SIGNED 28 Sept 66	
22c. PHYSICIAN'S NAME (Type) A.E. MANCE MD.		22d. ADDRESS OAKLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/1/66	23c. NAME OF CEMETERY OR CREMATORIAL Penn Catholic Cem.
23d. LOCATION (City or Town) Westmoreland Co., Pa.		(County) (State)	
24. FUNERAL DIRECTOR John O. Durst Leighton-Durst Funeral Home, Oakland, Md.		25a. ADDRESS John O. Durst	25b. RECEIVED BY REGISTRAR DATE OCT 3 1966
		25b. REGISTRAR'S SIGNATURE Charles Judge	

